DATE: [Date]

TO: Admitting Nurse / Administrator

FACILITY: [Name of Skilled Nursing Facility]

RE: Direct Admission / Transfer of Patient

PATIENT INFORMATION

Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Insurance: [Insurance Provider/ID]

CLINICAL SUMMARY

Reason for Transfer: [e.g., Acute Respiratory Infection, UTI, Fall Evaluation]
Presenting Symptoms: [List symptoms observed at Urgent Care]
Vital Signs: BP: [BP], HR: [HR], Temp: [Temp], SpO2: [O2 Sat]%

DIAGNOSTICS & TREATMENT

Tests Performed: [e.g., X-ray, Flu/COVID Swab, Urinalysis]
Results: [Brief summary of findings]
Medications Administered: [List medications given at clinic and time]

TRANSFER ORDERS / RECOMMENDATIONS

- [Order 1: e.g., Start Course of Oral Antibiotics]
- [Order 2: e.g., Frequent Vital Sign Monitoring]
- [Order 3: e.g., Weight Bearing Status]
- [Order 4: e.g., Follow up with PCP in X days]

CONTACT INFORMATION

Referring Provider: [Provider Name, Title]
Clinic Name: [Urgent Care Name]
Phone Number: [Direct Phone Line]
Fax: [Fax Number]

_____
Provider Signature